Commonwealth of Massachusetts
Executive Office of Health and Human Services

June 2008 *Version 8.0*

Companion Guide

Health Care Claim Status Request and Response

For ASC X12N 276/277 (Version 4010A1)

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Table of Contents

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1.0 Introduction

1.1 What Is HIPAA?

The Health Insurance Portability and Accountability Act of 1996 – Administrative Simplification (HIPAA-AS) – requires that MassHealth, and all other health-insurance payers in the United States, comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services (HHS). HHS has adopted an Implementation Guide for each standard transaction. The ASC X12N 276/277 (Version 4010A) transaction is the established standard for claim status inquiry.

1.2 Purpose of the Implementation Guide

The X12N 276/277 Version 4010A Implementation Guide for Claim Status Inquiry has been established as the standard for claim status compliance. The Implementation Guide contains requirements for use of specific segments and specific data elements within the segments. It was written for all health care providers and other submitters. It is critical that your software vendor or IT staff review this document carefully and follow its requirements to submit HIPAA-compliant files to MassHealth.

1.3 How to Obtain Copies of the Implementation Guides

The Implementation Guides for X12N 276/277 Version 4010A and all HIPAA transaction are available electronically at www.wpc-edi.com/HIPAA.

1.4 Purpose of This Companion Guide

This companion document was created for trading partners to supplement the 276/277 Implementation Guide. It describes the data content, business rules and characteristics for both transaction sets required by the MassHealth. The information in this guide supersedes all other communications from the MassHealth regarding this electronic transaction.

1.5 Intended Audience

The intended audience for this document is the technical area that is responsible for creating claim status inquires and interpreting the claim status response received from the MassHealth.

2.0 General Information

For questions regarding any issues in this companion guide, providers may contact MassHealth Customer Service by mail, phone, fax, or e-mail.

MassHealth Customer Service
P.O. Box 9118
Hingham, MA 02043

Phone: 1-800-841-2900
Fax: 617-988-8971
E-mail: hipaasupport@mahealth.net

3.0 Establishing Connectivity with MassHealth

All MassHealth trading partners must sign a Trading Partner Agreement (TPA). If you have elected to have a third party perform electronic transactions on your behalf you may be requested to complete a trading partner profile (TPP) form as well. Note that TPP information may be given over the telephone or the Provider Online Service Center in lieu of completing a paper form. If you have already completed these forms, you do not have to complete them again. Please contact MassHealth Customer Service at 1-800-841-2900 (see Section 2.0: General Information) if you have any questions about these forms.

Type of Contact	Area Contact	Telephone Number	E-Mail Address
Technical	Customer Service	1-800-841-2900	Hipaasupport@mahealth.net

3.1 Setup

MassHealth trading partners should submit HIPAA 276/277 transactions to MassHealth via the Provider Online Service Center, or system-to-system using our Healthcare Transaction Service (HTS) process. Trading partners must contact MassHealth Customer Service at 1-800-841-2900 with questions about these options and to obtain a copy of the HTS guide.

After establishing a transmission method, each trading partner must successfully complete testing. Information on this phase is provided in the next section of this companion guide (see Section 3.2 - Trading Partner Testing). After successful completion of testing, 276/277 transactions may be submitted for production processing.

This section provides information needed by the provider to establish connectivity with MassHealth for test and production, including

- communications software recommendations;
- file software recommendation (PC emulation, modem, settings); and
- password maintenance instructions.

3.2 Trading Partner Testing

This section describes the details that are needed for testing phase. Each trading partner wishing to process transactions in a batch environment will be tested. Batch analysis will be done by the EDI coordinator. Call the technical contact to begin testing at the telephone number above. Real-time transactions must be conducted through a predefined access method.

Things to do prior to contacting the EDI technical contact:

- Review this companion guide in conjunction with 276/277 implementation guide
- Prepare the Trading Partner system for development of a 276 transaction
- Generate a Test file within the timeline of 14 days or less

3.3 General Information for Member Name

The member name segment accepts and returns 30 characters as required in the Implementation Guide. However, if a value is submitted on a transaction that is greater than what is stored in the NewMMIS member database, on the return transaction the following would occur:

- If a match is found on the database, the value stored on the database table is returned;
- If no match is found on the database, the value stored on the original incoming transaction will be returned.

Example
A provider submits an eligibility verification check (270) with a name that is 22 characters long, but the database currently stores only 20 of those characters. On the return transaction (271), the provider will receive only the first 20 characters of the name submitted, if a match is found on the database. If for some reason, the member name submitted is not a MassHealth member, and is not stored on the database (no match found), on the return transaction (271) the name would be returned exactly as it was originally submitted.

3.4 Technical Requirements

The current maximum file size for any 270 file submitted to MassHealth is 16 megabytes. If you have any questions, or would like to coordinate the processing of larger files, please contact MassHealth Customer Service at 1-800-841-2900 (see Section 2.0: General Information).

3.4.1 EVSpc Software

Make sure that you have the following:

- Pentium processor with Windows NT 4.0/9X/ME/2000/XP
- minimum of 32 MB of RAM (128 MB recommended)
- minimum of 60 MB of free space on a hard disk
- CD ROM drive, phone modem and/or high speed Internet access
- Microsoft Internet Explorer 4.0 or higher, and/or Netscape 4.0 or higher with Internet connectivity, OR a modem (2400 or higher) connected to the PC with a phone line available.

3.4.2 Provider Online Service Center

Make sure that you have the following:

- Microsoft Internet Explorer 4.0 or higher, and/or Netscape 4.0 or higher, and/or

AOL 5.0 or higher

- The browser is functional, but may not be supported
- Browser that is frame-enabled
- The facility is able to connect to an SSL site

3.4.3 Batch

You will need:

- The batch ASC X12 276/277 Version 4010A text file
- To adhere to the compliance guidelines stated in this companion guide

3.4.4 Reporting

The purpose of this section is to identify and describe claim status related reports issued by MassHealth. Detailed claim status reports are available on the Provider Online Service Center and can also be produced via the EVSpc software application.

4.0 MassHealth-specific Data Requirements

4.1 General Information

The following information is provided to clarify code values, conditional data elements, and segments that are used by MassHealth in creating the 276/277 transactions. The following information is designed to help trading partners to pass the 276/277 transactions testing. This information is subject to change as the 276/277 transactions are updated.

4.2 Interchange Control Header and Group Header Changes

276 Implementation Guide Data

Loop	Segment ID/Data Element Number	Description	276 Requirement	MassHealth Instruction
	ISA01	Interchange Control Header	Required	To start and identify an interchange of zero or more functional groups and interchange-related control segments The first three characters in the transaction must be "ISA." The fourth character or field separator value must be a special character and cannot be the same as the segment separator. One of the following is recommended. "~", "^", "*", "<", ">", "{", "}", "[", "]", "|". The length of the ISA segment must be 106 characters. The last character of the segment, the segment separator, must be a special character and different from the field separator or the component separator. One of the following is recommended. "~", "^", "*", "<", ">", "{", "}", "[", "]", "|". Each field on the segment must be exactly the length as stated in the HIPAA guide.
	ISA01/ I01	Authorization Information Qualifier	Required	Must equal "00."

	ISA02/ I02	Authorization Information	Required	Must equal 10 blanks.
	ISA03/ I03	Security Information Qualifier	Required	Must equal “00.”
	ISA04/ I04	Security Information	Required	Must equal 10 blanks.
	ISA05/ I05	Interchange ID Qualifier	Required	Must equal “ZZ.”
	ISA06/ I06	Interchange Sender ID	Required	Must equal the nine-digit MassHealth provider number plus service location.
	ISA07/ I05	Interchange ID Qualifier	Required	Qualifier to designate the system/method if code structure used to designate the sender or receiver ID element being qualified. Must equal “ZZ.”
	ISA08/ 07	Interchange Receiver ID	Required	Identification code published by the receiver of the data, when sending. It is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them. Must equal “DMA7384.” Eight trailing spaces are required to equal fifteen characters.
	ISA014/I13	Acknowledgement Requested	Required	Must equal “0.”
	ISA015/I14	Usage Indicator	Required	Must equal “P” for production submission, “T” for test submission.
	IEA	Interchange Control Trailer	Required	To define the end of an interchange of zero or more functional groups and interchange related control segments. The first three characters in the segment must be “IEA.”
	IEA01/ I16	Number of Included Functional Groups	Required	A count of the number of functional groups included in an interchange. Must equal “1” for the transaction to qualify for immediate response. A value greater than one causes the entire transaction to be processed in a nightly batch process, with a response available within one business day.

	IEA02/ I12	Interchange Control Number	Required	A control number assigned by the interchange sender. Must equal the value of ISA13 on the preceding ISA segment.
	GS	Functional Group Header	Required	To indicate the beginning of a functional group and to provide control information. The first two characters in the segment must be “GS.”
	GS01/ 479	Functional Identifier Code	Required	Code identifying a group of application-related transaction sets. Must equal “HR” for a claim status inquiry or “HN” for a claim status response.
	GS02/ 142	Application Sender’s Code	Required	Code identifying party sending transmission, codes agreed to by trading partners. Nine-digit MassHealth provider number plus service location
	GS03/ 124	Application Receiver’s Code	Required	Code identifying party sending transmission, codes agreed to by trading partners. Must equal “DMA7384.”
	GE	Functional Group Trailer	Required	To indicate the end of a functional group and to provide control information. The first two characters in the segment must be “GE.”
	GE01/97	Number of Transaction sets included	Required	Must equal “1” for the interactive transaction to qualify for immediate response.

Loop	Segment ID/Data Element Number	Description	276 Requirement	MassHealth Instruction
	IEA	Interchange Control Trailer	Required	To define the end of an interchange of zero or more functional groups and interchange related control segments. The first three characters in the segment must be "IEA."
	IEA01/ I16	Number of Included Functional Group	Required	A count number of functional groups included in an interchange. Must equal "1" for the transaction to qualify for immediate response. A value greater than one causes the entire transaction to be processed in a nightly batch process with a response available within one business day.
	IEA02/ I12	Interchange Control Number	Required	A control number assigned by the interchange sender. Must equal the value of ISA 13 on the preceding ISA segment.
	ST	Transaction Set Header	Required	To indicate the start of a transaction set and to assign a control number. The first two characters in the segment must be "ST." The ST segment must be immediately followed by the GS segment for immediate response. If a second ST segment is found prior to a GE segment, the entire transaction is processed as an overnight batch.

276 Implementation Guide Data

010	ST01/ 143	Transaction Set Identifier Code	Required	If the value of GS01 is "HR", delete 1st sentence. Must equal "276" if the value of GS01 is "HR."
010	ST02/ 329	Transaction Set Control Number	Required	Must be equal to ST02 on the following SE segment.
010	ST01/ 143	Transaction Set Identifier Code	Required	Must equal "277" if the value of GS01 is "HN."

010	ST02/ 329	Transaction Set Control Number	Required	Must be equal to “ST02” on the following SE segment.
	SE	Transaction Set Trailer	Required	To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning of (ST) and ending (SE) segments)
160	SE01/96	Number of included segments	Required	Total number of segments included in a transaction set including ST and SE segment
160	SE02/ 329	Transaction Set Control Number	Required	Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transactions set
	BHT	Transaction Set Trailer	Required	To define business hierarchical structure of the transaction set, identify the business application purpose and reference data, i.e., number, date and time. The first three characters in the segment must be “BHT.”
020	BHT101/1005	Hierarchical Structure Code	Required	Must equal “0010” for the 276 transaction. Please note that this implementation of claim status ignores the dependent level if present on the request.
020	BHT02/ 353	Transaction Set Purpose Code	Required	Code identifying the purpose of transaction set. Must equal “I3” for both request transactions.
020	BHT04/ 373	Date	Required	Must be a valid date in the format CCYYMMDD. It cannot be a date in the future.

Loop	Segment ID/Data Element Number	Description	276 Requirement	MassHealth Instruction	997 AK Value
276 Implementation Guide Data				**Payer Specific Information**	
2000A	HL	Hierarchical Level	Required	To identify dependencies among and the content of hierarchically related groups of data segments. HL segment is required to cover only one time. The first two characters in the segment must be "HL."	AK3*HL*..*..*3~
010	HL01/ 628	Hierarchical ID Number	Required	Must be numeric value that increments by one for each HL segment within the transaction set.	AK304=8 AK4*1*628*7* HL01 value~
010	HL03/ 735	Hierarchical Level Code	Required	Must equal "20" for the information source HL segment	AK3*HL*3*2000A*3~ AK4*3*735*7*HL03 value~
010	HL04/ 736	Hierarchical Child Code	Required	Must equal "1" for all HL segments other than the subscriber HL segment for which the value must be "1."	AK304=8 AK4*3*736*7*HL04 value~
2000B	HL	Hierarchical Level	Required	To identify dependencies among and the content of hierarchically related groups of data segments. HL segment is required to cover only one time. The first two characters in the segment must be "HL."	AK3*HL*..*..*3~
010	HL01/ 628	Hierarchical ID Number	Required	Must be numeric value that increments by one for each HL segment	AK304=8 AK4*1*628*7*

				within the transaction set.	HL01 value~
010	HL02/ 734	Hierarchical Parent ID Number	Required	Must contain HL01 value of the previous HL or parent HL segment for all other level.	AK304=8 AK4*2*734*7*HL02 value~
010	HL03/ 735	Hierarchical Level Code	Required	Must equal “20” for the information source HL segment.	AK3*HL*3*2000A*3~ AK4*3*735*7*HL03 value~
010	HL04/ 736	Hierarchical Child Code	Required	Must equal “1” for all HL segments other than the subscriber HL segment for which the value must be “1.”	AK304=8 AK4*3*736*7*HL04 value~
2000C	HL	Hierarchical Level	Required	To identify dependencies among and the content of hierarchically related groups of data segments. HL segment is required to cover only one time. The first two characters in the segment must be “HL.”	AK3*HL*..*..*3~
010	HL01/ 628	Hierarchical ID Number	Required	Must be numeric value that increments by one for each HL segment within the transaction set.	AK304=8 AK4*1*628*7* HL01 value~
010	HL02/ 734	Hierarchical Parent ID Number	Required	Must contain HL01 value of the previous HL or parent HL segment for all other level.	AK304=8 AK4*2*734*7*HL02 value~
010	HL03/ 735	Hierarchical Level Code	Required	Must equal “20” for the information source HL segment.	AK3*HL*3*2000A*3~ AK4*3*735*7*HL03 value~
010	HL04/ 736	Hierarchical Child Code	Required	Must equal “1” for all HL segments other than the subscriber HL segment for which the value must be “1.”	AK304=8 AK4*3*736*7*HL04 value~
2000D	HL	Hierarchical	Required	To identify	AK3*HL*..*..*3~

		Level		dependencies among and the content of hierarchically related groups of data segments. HL segment is required to cover only one time. The first two characters in the segment must be "HL."	
010	HL01/ 628	Hierarchical ID Number	Required	Must be numeric value that increments by one for each HL segment within the transaction set.	AK304=8 AK4*1*628*7* HL01 value~
010	HL02/ 734	Hierarchical Parent ID Number	Required	Must contain HL01 value of the previous HL or parent HL segment for all other levels.	AK304=8 AK4*2*734*7*HL02 value~
010	HL03/ 735	Hierarchical Level Code	Required	Must equal "20" for the information source HL segment.	AK3*HL*3*2000A*3~ AK4*3*735*7*HL03 value~
010	HL04/ 736	Hierarchical Child Code	Required	Must equal "1" for all HL segments other than the subscriber HL segment for which the value must be "1."	AK304=8 AK4*3*736*7*HL04 value~

Assumptions:

- To remain consistent with the HIPAA Implementation Guide the value "HL" is defined in this document as HL00.
- The EVS implementation of the HIPAA 276 transaction set does not recognize the dependent loop.
- The real-time implementation of the HIPAA 276 transaction set recognizes only one occurrence of the HL segment for each of the hierarchical levels within each ST through SE transaction set. Additional occurrences of this segment and the segments included within the additional HL loop will be ignored.
- The HIPAA 277 real-time response transactions for claim status will include up to 100 member-level loops beginning with the HL segment. Each loop contains the status information of a claim that satisfies the request criteria up to 99 loops. The 100th loop, if present, indicates by codes in the STC segment that more than 99 claims on the database satisfy the criteria.

Loop	Segment ID/Data Element Number	Description	276 Requirement	MassHealth Instruction	997 AK Value
276 Implementation Guide Data				**Payer Specific Information**	
2100A	**Information Source Name**				
2100	NM1	Individual or Organizational Name	Required	To supply the full name of an individual or organizational entity. The first three characters in the segment must be "NM1." One and only one NM1 segment is required following each HL segment.	AK3*NM1*..*..*3~
030	NM101/ 98	Entity Identifier Code	Required	Must equal "PR."	AK3*NM1*4*2100A*8~
030	NM102/1065	Entity Type Qualifier	Required	Code qualifying the type of entity. Must equal "2."	AK304=8 AK4*2*1065*7*NM102 value~
030	NM103/1035	Name Last or Organization Name	Required	Individual's last name or organization name MassHealth	AK304=8 AK4*3*1035*7*NM103 value~
030	NM104/ 1036	Name First	Not used	Individual's first name	N/A
030	NM105/ 1037	Name Middle	Not used	Individual's middle name or initial	N/A
030	NM106/ 1038	Name Prefix	Not used	Prefix to individual's name	N/A
030	NM107/ 1039	Name Suffix	Not used	Suffix to individual's name	N/A
030	NM108/66	Identification	Required	Code	AK304=8

		Code Qualifier		designating the system/method of code structure used for identification code (67)	AK4*8*66*7*NM107 value~
030	NM109/67	Identification Code	Required	Code identifying a party or other code. Must equal 046002284.	Ak304=8 AK4*8*67*7*NM109 value~
2100B		**Information Receiver Name**			
2100	NM1	Individual or Organizational Name	Required	To supply the full name of an individual or organizational entity. The first three characters in the segment must be "NM1." One and only one NM1 segment is required following each HL segment.	AK3*NM1*..*..*3~
030	NM101/ 98	Entity Identifier Code	Required	Must equal "PR."	AK3*NM1*4*2100A*8~
030	NM102/1065	Entity Type Qualifier	Required	Code qualifying the type of entity. Must equal "2."	AK304=8 AK4*2*1065*7*NM102 value~
030	NM103/1035	Name Last or Organization Name	Required	Individual's last name or organizational name MassHealth	AK304=8 AK4*3*1035*7*NM103 value~
030	NM104/ 1036	Name First	Situational	Individual's first name	N/A

276 Implementation Guide Data				Payer Specific Information	
Loop	**Segment ID/Data Element Number**	**Description**	**276 Requirement**	**MassHealth Instruction**	**997 AK Value**
030	NM108/66	Identification Code Qualifier	Required	Code designating the system/method of code structure used for identification code (67)	AK304=8 AK4*8*66*7*NM107 value~
030	NM109/67	Identification Code	Required	Code identifying a party or other code. Must equal 046002284.	Ak304=8 AK4*8*67*7*NM109 value~
2100C		**Service Provider Name**			
2100	NM1	Individual or Organizational Name	Required	To supply the full name of an individual or organizational entity. The first three characters in the segment must be “NM1.” One and only one NM1 segment is required following each HL segment. If the member ID is not coded in NM109 and the member’s card ID and sequence number are not coded of the REF*GH*… segment, the member’s last name and first initial are required in the	AK3*NM1*..*..*3~

				NM103 and NM104 fields. If NM108 equals "MI" at the subscriber level, NM109 must equal a valid member ID. The member ID must contain exactly 12 alphanumeric characters. The last seven positions must be numeric. NM102 through NM107 should follow the HIPAA guidelines for all levels other than the information source hierarchical level.	
050	NM101/ 98	Entity Identifier Code	Required	Must equal "1P."	AK304=8 AK4*1*98*7*NNM101 value~
050	NM102/1065	Entity Type Qualifier	Required	Code qualifying the type of entity. Must equal "1."	AK304=8 AK4*2*1065*7*NM102 value~
050	NM103/1035	Name Last or Organization Name	Required	Individual Last name or organization name Must equal "XYZ" hospital.	AK304=8 AK4*3*1035*7*NM103 value~
050	NM108/ 66	Identification Code Qualifier	Required	Must equal "XX."	AK304=8 AK4*8*66*7*NM108 value~
050	NM109/67	Identification Code	Required	Code identifying a party or other code. Enter NPI or, if an atypical provider, MassHealth provider ID and	AK304=8 AK4*9*67*7*NM109 value~

				service location.	

276 Implementation Guide Data				Payer Specific Information	
2100C	**Subscriber Name**				
Loop	**Segment ID/Data Element Number**	**Description**	**276 Requirement**	**MassHealth Instruction**	**997 AK Value**
2100	NM1	Individual or Organizational Name	Required	To supply the full name of an individual or organizational entity. The first three characters in the segment must be “NM1.” One and only one NM1 segment is required following each HL segment. If the member ID is not coded in NM109 and the member’s card ID and sequence number are not coded of the REF*GH*… segment, the member’s last name and first initial are required in the NM103 and NM104 fields. If NM108 equals “MI” at the subscriber level, NM109 must equal a valid member ID. The member ID must contain exactly 12 alphanumeric characters. The last seven	AK3*NM1*..*..*3~

				positions must be numeric. NM102 through NM107 should follow the HIPAA guidelines for all levels other than the information source hierarchical level.	
050	NM101/ 98	Entity Identifier Code	Required	Must equal QC or IL.	AK304=8 AK4*1*98*7*NNM101 value~
050	NM102/1065	Entity Type Qualifier	Required	Must equal “1.”	AK304=8 AK4*2*1065*7*NM102 value~
050	NM103/1035	Name Last or Organization Name	Required	Individual last name or organization name Must contain at least one character, does not need to be related to subscriber information. Recommended value equal to “A.”	AK304=8 AK4*3*1035*7*NM103 value~
050	NM108/ 66	Identification Code Qualifier	Required	Code designating the system/method of code structure used for identification code (67). Must equal MI.	AK304=8 AK4*8*66*7*NM108 value~
050	NM109/67	Identification Code	Required	Code identifying a party or other code. Must equal a valid member ID If inquiring by ICN or medical record number (patient account	AK304=8 AK4*9*67*7*NM109 value~

				number), does not need to be related to subscriber information.	

276 Implementation Guide Data				Payer Specific Information	
Loop	**Segment ID/Data Element Number**	**Description**	**276 Requirement**	**MassHealth Instruction**	**997 AK Value**
2200D		**Claim Submitter Trace Number**			
2200	REF	Reference Identification	Required	To specify identifying information. The first three characters in the segment must be "REF."	AK3*REF*..*2000B*3~
100	REF01/ 128	Reference Identification Qualifier	Required	Code qualifying the reference identification. A REF segment with REF01 equal to "1K" is allowed at the claim level for the 276 claim status request transaction. The value in REF02 is MassHealth ICN.	STC…
100	REF02/ 127	Reference Identification	Required	Reference information as defined for a particular transaction set or as specified by the reference identification qualifier.	
2100C		**Subscriber Demographic Information**			
2100	DMG	Subscriber	Required	To supply	

		Name		demographic information. The first three characters in the segment must be “DMG.”	
100	DMG01/1250	Date Time Period Format Qualifier	Required	Code indicating the date format, time format, or date and time format. DMG is in loop 2000D and 2000E. Required when inquiring by name. Must equal “D8.”	AK3*DMG*..**8- AK4*1*1250*7*DMG01 value~
100	DMG03	Gender Code	Required	Code indicating the sex of the individual. Must equal “F,” “M,” or “U” when coded on the 276 transaction.	AK3*DMG*..**8- AK4*1*1068*7*DMG03 value~
2200D	**Claim Submitter Trace Number**				
2200	TRN	Trace	Required	To uniquely identify a transaction to an application. TRN00, the first three characters in the segment must be “TRN.” The TRN segment is required for the 276 claim status request transaction.	AK3*TRN*..**2000C*3~-
090	TRN01/ 481	Trace Type Code	Required	Code identifying which transaction is being referenced.	

				Must equal “1” for the 276 claim status request transaction.	
090	TRN02/127	Reference Identification	Required	Reference information is defined for a particular transaction set or as specified by the reference identification qualifier. Must equal present but the value will not be edited for the 276 claim status request transaction. Maximum characters 30.	
276 Implementation Guide Data				**Payer Specific Information**	
Loop	**Segment ID/Data Element Number**	**Loop**	**Segment ID/Data Element Number**	**Loop**	**Segment ID/Data Element Number**
2200D	**Claim Submitter Trace Number**				
2200	AMT	Monetary Amount	Required	To indicate the total monetary amount. The first three characters in the segment must be “AMT.” The AMT segment is required for the 276 claim status request transaction.	AK3*AMT*..**2000C*3~-
110	AMT01/ 522	Amount Qualifier Code	Required	Must equal “T3” for the 276 claim status request	

				transaction.	
110	AMT02/782	Monetary Amount	Required	Monetary amount. Use 0.00 to inquire upon all amounts. If non-zero amount is entered, the response will be filtered to equal only the amount provided. Must be a valid monetary amount on the 276 claim status request transaction.	
2200D	**Claim Submitter Trace Number**				
2200	DTP	Date or Time or Period	Required	Code indicating the date format, time format, or date and time format. The first three characters in the segment must be “DTP.”	AK3*DTP*..**2100C*3~-
120	DTP01/ 374	Date/Time Qualifier	Required	Must equal "232" for the 276 transaction when the segment is present at the claim level, that is, before the SVC segment. Must equal “472" for the 276 transaction when the SVC segment is included in the request.	AK304=8 AK4*1*374*7*DTP01 value~
120	DTP02/ 1250	Date Time Period Format	Required	Code indicating the date format, time format, or	AK304=8 AK4*2*1250*7*DTP02 value~

		Qualifier		date and time format. Must equal "RD8" for the 276 transaction within the subscriber loop.	
120	DTP03/ 1251	Date Time Period	Required	Code indicating the date format, time format, or date and time format. Must be two valid dates in CCYYMMDD format separated by a dash. The first date must be less than or equal to the second date. The dates cannot be future dates. For a real-time request, the difference between the two dates cannot exceed six months. If processing in batch environment, then 36 months is the greatest difference between the first and second dates.	AK304=8 AK4*3*1251*7*DTP03 value~

Loop	Segment ID/Data Element Number	Description	276 Requirement	MassHealth Instruction	997 AK Value
276 Implementation Guide Data				**Payer Specific Information**	
2210D		**Service Line Information**			
130	SVC01/C003	Composite Medical Producer Identifier	Required	To identify a medical procedure by its standardized codes and applicable modifiers. A required composite field of the format "HC:5-character HCPCS code" or "AD:five-character American Dental Association Code" or "NU:3-character OP-Revenue code.	
130	SVC01-1/235	Product/ Service ID Qualifier	Required	Code identifying the type/source of the descriptive number used in product/service ID (234).	
130	SVC01-2/234	Product/ Service ID	Required	Identifying number for a product or a service	
130	SVC01-3/1339	Procedure Modifier	Situational	This identifies special circumstances related to the performance of the service as defined by trading partners.	

130	SVC01-4/1339	Procedure Modifier	Situational	This identifies special circumstances related to the performance of the service as defined by trading partners.	
130	SVC01-5/1339	Procedure Modifier	Situational	This identifies special circumstances related to the performance of the service as defined by trading partners.	
130	SVC01-6/1339	Procedure Modifier	Situational	This identifies special circumstances related to the performance of the service as defined by trading partners.	
130	SVC02/782	Monetary Amount	Required	Monetary amount A required field containing a valid monetary amount value. A decimal point is required prior to the two decimal places to represent a non-integer value. Zero is a valid value.	
130	SVC04/ 234	Product/ Service ID	Situational	Identifying number for a product or service	
130	SVC07/ 380	Quantity	Situational	Numeric value of quantity	

276 Implementation Guide Data				Payer Specific Information	
Loop	**Segment ID/Data Element Number**	**Description**	**276 Requirement**	**MassHealth Instruction**	**997 AK Value**
2200D		**Claim Submitter Trace Number**			
2200	STC	Status Information	Required	To report the status, required action and paid information of a claim or service line	
100	STC01/C043	Health Care Claim Status	Required	Used to convey status of the entire claim or a specific service line	
100	STC01-1/1271	Industry Code	Required	Code indicating a code from a specific industry code list	
100	STC01-2/1271	Industry Code	Required	Code indicating a code from a specific industry code list	
100	STC01-3/98	Entity Identifier Code	Situational	Code identifying an organizational entity, physical location, property, or individual	
100	STC02/373	Date	Required	Date expressed as CCYYMMDD	
100	STC03/306	Action Code	Not Used		
100	STC04/782	Monetary Amount	Required	Monetary amount	
100	STC05/782	Monetary Amount	Required	Monetary amount	
100	STC06/373	Date	Situational	Date expressed as CCYYMMDD	
100	STC07/591	Payment Method Code	Situational	Code identifying the method for the movement of payment instructions	
100	STC08/373	Date	Situational	Date expressed as CCYYMMDD	
100	STC09/429	Check Number	Situational	Check identification number	
100	STC10/C043	Health Care Claim Status	Situational	Used to convey status of the entire claim or a specific service	
100	STC10-	Industry	Required	Code indicating a code from	

	1/1271	Code		a specific industry code list	
100	STC10-2/1271	Industry Code	Required	Code indicating a code from a specific industry code list	
100	STC10-3/98	Entity Identifier Code	Situational	Code identifying an organizational entity, physical location, property, or individual	
100	STC11/ C043	Health Care Claim Status	Situational	Used to convey status of the entire claim or a specific service	
100	STC11-1/1271	Industry Code	Required	Code indicating a code from a specific industry code list	
100	STC11-2/1271	Industry Code	Required	Code indicating a code from a specific industry code list	
100	STC11-3/1271	Entity Identifier Code	Situational	Code identifying an organizational entity, physical location, property, or individual	

5.0 Assumptions

5.1 ISA Segment

- The fourth character ("*") is identified as the field separator throughout the entire transaction.
- The final character ("~") is identified as the segment separator throughout the entire transaction.
- The ":" is identified as the component element separator throughout the entire transaction.
- To remain consistent with the HIPAA guide, the value "ISA" is defined in this document as ISA00.
- ISA02 and ISA04 are set to spaces on the response transaction.
- ISA06 and ISA08 are reversed on the response transaction.

5.2 IEA Segment

- To remain consistent with the HIPAA guide, the value "IEA" is defined in this document as? IEA00.

5.3 GE Segment

- To remain consistent with the HIPAA guide, the value "GS" is defined in this document as GS00.
- The GS segment immediately follows the 106th character of the ISA segment.
- GS02 and GS03 are reversed on the response transaction.
- GS01 will equal "HR" for claim status request and "HN" for claim status response notification.

5.4 ST Segment

- To remain consistent with the HIPAA guide, the value "ST" is defined in this document ST00.
- On the response, ST01 will equal "227" when the value of GS01 is "HN."

5.5 SE Segment

- To remain consistent with the HIPAA guide, the value "SE" is defined in this document as SE00.
- No loop identifier code is defined for SE segment.

5.6 BHT Segment

- To remain consistent with the HIPAA guide, the value "BHT" is defined in this document as BHT00.

5.7 HL Segment

- To remain consistent with the HIPAA guide, the value "HL" is defined in this document HL00.
- The EVS implementation of the HIPAA 276 transaction set code does not recognize the dependent loop.
- The real-time implementation of the HIPAA 276 transaction set recognizes only one occurrence of the HL segment for each of the hierarchical levels within each ST through SE transaction set. Additional occurrences of this segment and the segments included within the additional HL loop will be ignored.
- The HIPAA 277 real-time response transaction for claim status will include up to 100 member-level loops beginning with the HL segment. Each loop contains the status information of a claim that satisfies the request criteria up to 99 loops. The 100th loop, if present, indicates by codes in the STC segment that more than 99 claims on the database satisfy the criteria.

5.8 NM1 Segment

- To remain consistent with the HIPAA guide, the value "NM1" is defined in this document as NM100.
- If a provider uses a billing agency to request claim status information, the provider must inform MassHealth Customer Service.
- When the member identification number is used as the inquiry variable, NM108 must equal "MI" and NM109 must contain the member ID.
- On the response transaction at the subscriber level, member name and number from the information source database will replace values present on the request NM1 segment.

5.9 REF Segment

- To remain consistent with the HIPAA guide, the value "REF" is defined in this document as REF00.
- This segment can be coded at the claim or detail level on the 276 claim status request transaction. When coded at the detail level, the REF segment is ignored.
- More than the HIPAA-allowed maximum of three REF segments will be ignored when included within the 276 claim status request transaction. None of the REF segments are required.
- When coded on the 276 claim status request transaction, REF segments with REF01 other than "1K" and "EA" are ignored.
- The claim reference number (ICN) is available to the provider on the RA. When this field is present on the 276 REF*&K*… segment it will serve as the primary search value for claims on the EVS database. If no claim for this provider is found with this ICN, the member ID entered on the subscriber detail NM1 segment will be used as the search key. When only nine characters of the 13-character ICN are entered in REF02 field, all claim records having the same first nine characters will be returned in the response.
- When a REF*EA*… segment is received within a 276 transaction, it is used with the

billing provider number as claim selection criteria if the ICN and member ID fields do not return at least one claim.

5.10 DMG Segment

- To remain consistent with the HIPAA guide, the value "DMG" is defined in this document as DMG00.
- The DMG segment is coded within the subscriber loop on the 276 claim status request transaction. Please note that the loop IDs at this level are different for the two request transactions.

5.11 TRN Segment

- To remain consistent with the HIPAA guide, the value "TRN" is defined in this document as TRN00.
- The TRN segment can occur at the subscriber level on the 270 eligibility verification transaction but is not required. If the TRN segment is present on the 270, none of the fields on the segment will be edited. The unaltered segment will be returned on the resulting response transaction.
- For the 276 claim status request transaction, the TRN segment is required when the subscriber is the patient. Because in the MassHealth implementation of HIPAA, the subscriber is always the patient, this segment is always required.
- The TRN segment received on the 276 claim status request transaction will be returned unaltered on the 277 response transaction except that TRN01 will be changed to "2."

5.12 AMT Segment

- To remain consistent with the HIPAA guide, the value "AMT" is defined in this document as AMT00.
- For the 276 claim status request transaction, the AMT segment is required when the subscriber is the patient. Because in the MassHealth implementation of HIPAA, the subscriber is always the patient, this segment is always required.
- For the 276 claim status request transaction, if AMT02 is greater than zero, the value will be used as a secondary match criterion when selecting claims to include on the response. Only claims that have an exact dollar amount match will be returned.
- For the 276 claim status request transaction, AMT02 must contain a decimal point if it contains a non-integer value.

5.13 DTP Segment

- To remain consistent with the HIPAA guide, the value "AMT" is defined in this document as AMT00.

5.14 SVC Segment

- To remain consistent with the HIPAA guide, the value "AMT" is defined in this document as AMT00.

- The SVC segment can only be included within the 276 claim status request transaction at the service line information level.
- For the EVS implementation of the HIPAA 276 claim status transaction, the medical service code entered in SVC01 will be used as a filter when selecting claims from the database.
- For the EVS implementation of the HIPAA 276 claim status transaction, a non-zero monetary amount entered in SVC02 will be used as a filter when selecting claims from the database.
- If the transaction contains a REF segment where REF01 = "1K" and a valid TCN value is entered in REF02, the values entered in SVC01 and SVC02 will not be used as claim-selection filters.
- The SVC segment will be returned on the 277 claim status response transaction for call claims that process on a detail or line level.

6.0 PC Receive Response Edits

6.1 Receive _EDI_N3

6.1.1 Patient Address

If the benefit type is "NO Benefit", the patient address is a required field. If the 55 characters are not alphanumeric or are an invalid address, generate the error "Invalid/Missing Patient Address" with error code "97." Get the next field, if the next field is alpha-numeric, concatenate it to the patient address after carriage return line feed. Otherwise generate error "Invalid/Missing Patient Address" with error code "97."

6.1.2 PCC Address

If the benefit type is PCC, the PCC address is a required field. If the 55 characters are not alphanumeric or are an invalid address, generate the error "Invalid/Missing PCC Address" with error code "97." Get the next field, if the next field is alphanumeric concatenate it to the patient address after carriage return line feed, otherwise generate error "Invalid/Missing PCC Address" with error code "97."

6.1.3 Local Office Address

If the benefit type is LO Benefit, local address is a required field, if the 55 characters are not alphanumeric or invalid address; generate the following error "Invalid/Missing PCC Address" with error code "97". Get the next field, if the next field is alphanumeric concatenate it to the patient address after carriage return line feed, otherwise generate error "Invalid/Missing Local Office Address" with error code "97".

6.1.4 TPL Address

If the benefit type is TPL, TPL address is a required field, if the 55 characters are not

alphanumeric or invalid address; generate the following error “Invalid/Missing TPL Address” with error code “97”. Get the next field, if the next field is alphanumeric concatenate it to the patient address after carriage return line feed, otherwise generate error “Invalid/Missing TPL Address” with error code “97”.

6.1.5 Managed Care Office Address

If the benefit type is MCO, the MCO address is a required field, if the 55 characters are not alphanumeric or invalid address; generate the following error “Invalid/Missing Managed Care Provider Address” with error code “97”. Get the next field, if the next field is alphanumeric concatenate it to the patient address after carriage return line feed, otherwise generate error “Invalid/Missing Managed Care Provider Address” with error code “97”.

6.1.6 Long Term Care Provider Address

If the benefit type is LTC, the long term care provider address is a required field, if the 55 characters are not alphanumeric or invalid address; generate the following error “Invalid/Missing Long Term Care Provider Address” with error code “97”. Get the next field, if the next field is alphanumeric concatenate it to the patient address after carriage return line feed, otherwise generate error “Invalid/Missing Long Term Care Provider Address” with error code “97”.

6.2 Receive_EDI_N4

6.2.1 Patient Address

If the benefit type is “NO Benefit”, the patient address is a required field. Validate that the city is at least two characters and a maximum of 30 and that it is alphanumeric. Validate that the state is two alphabetic characters. Validate the zip code field.

6.2.2 PCC Address

If the benefit type is PCC, the PCC address is a required field. Validate that the city is at least two characters and a maximum of 30 and that it is alphanumeric. Validate that the state is two alphabetic characters. Validate the zip code field.

6.2.3 Local Office Address

If the benefit type is LO, the LO address is a required field. Validate that the city is at least two characters and a maximum of 30 and that it is alphanumeric. Validate that the state is two alphabetic characters. Validate the zip code field.

6.2.4 TPL Address

If the benefit type is TPL, the TPL address is a required field. Validate that the city is at least two characters and a maximum of 30 and that it is alphanumeric. Validate that the state is two alphabetic characters. Validate the zip code field.

6.2.5 Managed Care Office Address

If the benefit type is MCO, the MCO address is a required field. Validate that the city at least two characters and a maximum of 30 and that it is alphanumeric. Validate that the state is two alphabetic characters. Validate the zip code field.

6.2.6 Long Term Care Provider Address

If the benefit type is LTC, the long term care provider address is a required field. Validate that the city has at least two characters and a maximum of 30 and that it is alphanumeric. Validate that the state is two alphabetic characters. Validate the zip code field.

6.2.7 PCC Name

If the benefit type is PCC benefit, validate that the PCC name is alphanumeric with up to 35 characters.

6.2.8 PCC Number

If the benefit type is PCC benefit and the ID code is “SV,” validate that the PCC number is alphanumeric with a minimum of two and a maximum of 80 characters.

6.2.9 Local Office Name

If the benefit type is local office benefit, validate that the local office name is alphanumeric with up to 35 characters.

6.2.10 Local Office Number

If the benefit type is local office benefit, validate that the local office number is alphanumeric with a minimum of two and a maximum of 80 characters.

6.2.11 Third Party Liability Name

If the benefit type is third-party-liability benefit, validate that the third-party liability name is alphanumeric with up to 35 characters.

6.2.12 Third Party Liability Carrier

If the benefit type is third-party-liability benefit, validate that the third-party liability name is alphanumeric with a minimum of two and a maximum of 35 characters.

6.2.13 Managed Care Name

If the benefit type is managed care benefit, validate that the managed care name is alphanumeric with up to 35 characters.

6.2.14 Managed Care Number

If the benefit type is managed care benefit, and the ID code is “PI,” validate that the

managed care number is alphanumeric with a minimum of two and a maximum of 80 characters.

6.2.15 Long Term Care Provider

If the benefit type is long-term-care benefit, validate that the long-term-care facility is alphanumeric with up to 35 characters.

6.3 Receive_EDI_PER

6.3.1 Number Type

If the number type is alphanumeric and the number type is “TE” or “WP,” accept the phone number. If the number type is not “TE” or “WP,” repeat the validation for the next two groups.

6.3.2 SSN

If the segment type is not dependent, the benefit type is “NO Benefit” and the field ID is “SY,” get the SSN. If the SSN is not a nine-digit number, generate the error “Invalid SSN” and error code “43.”

6.3.3 Policy Number & Name

If the segment type is not dependent, the benefit type is TPL benefit, and the field is “IG” or “N6,” get the policy number and name.

6.3.4 Provider Name

If the segment type is not independent, the benefit type is LTC benefit, and the field ID is “1P,” get the provider name.

6.3.5 Managed Care Policy Number and Plan Name

If the segment type is not dependent, and the benefit type is MCO benefit, get the policy number and plan name. Describe the process that represents the requirement. Repeat for additional areas.

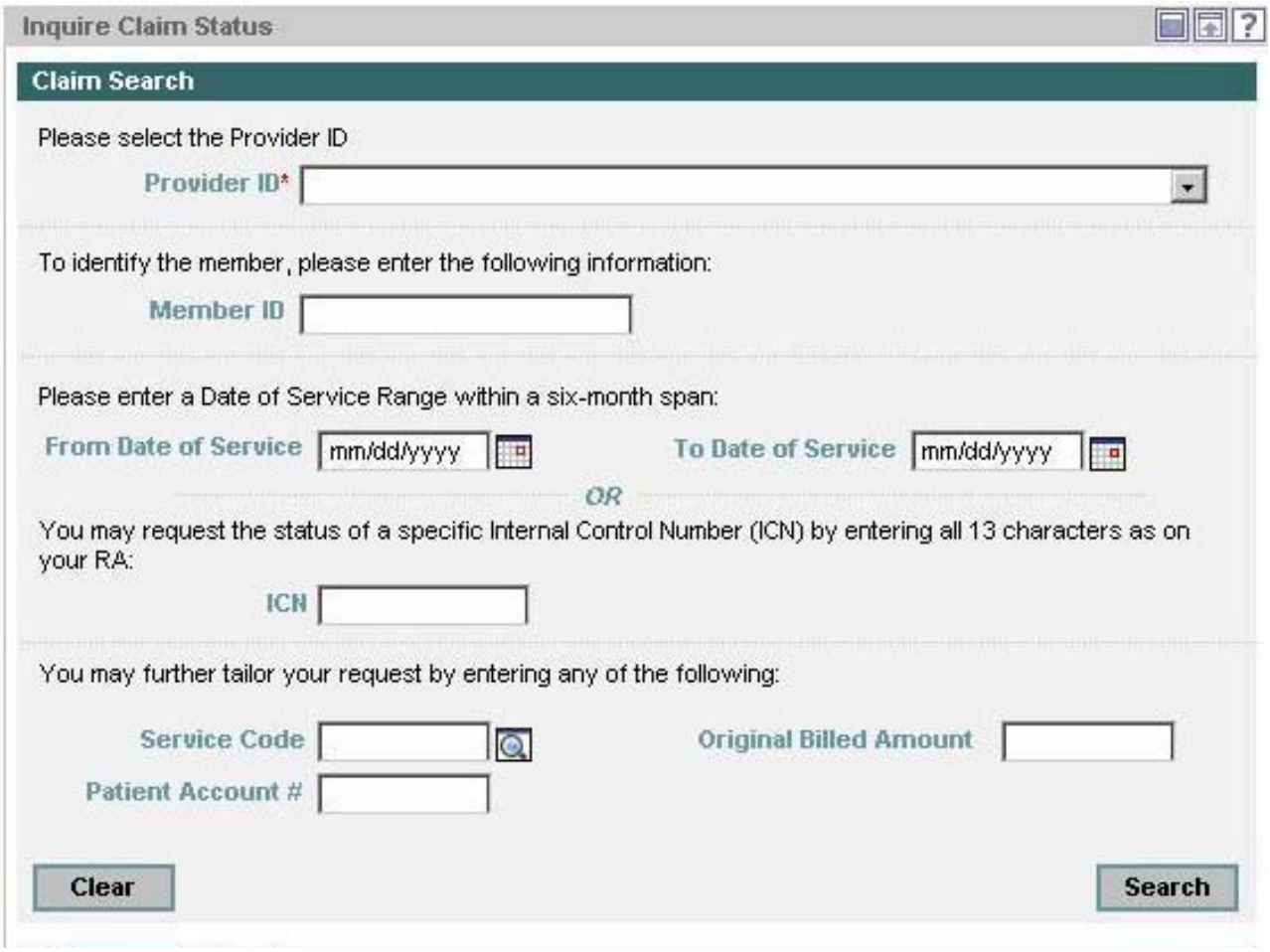
Appendix A: List of Segments and Error Codes

List of Segments and Error Codes

Segment Name	Error Code
Receive_EDI_270_Record	ZZ
Receive_EDI_DMG	58
Receive_EDI_DTP	56, 58
Receive_EDI_N3	97
Receive_EDI_N4	
Receive_EDI_NM1	64
Receive_EDI_PER	

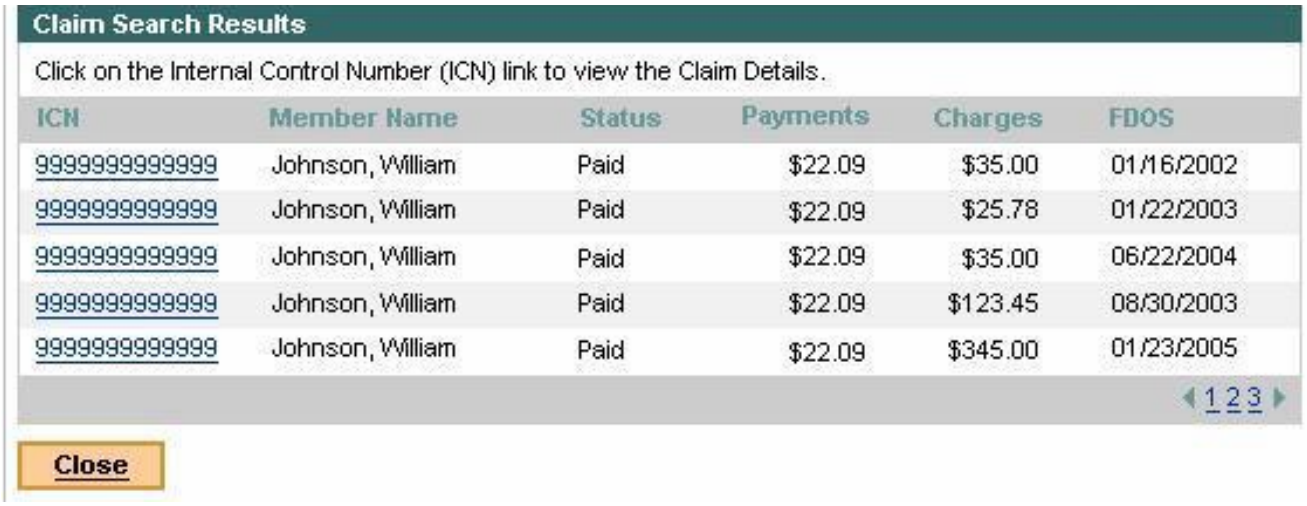
Appendix B: Claims Status Inquiry Panel

Claims Status Inquiry Panel



Appendix C: Claims Status Inquiry Results

Claims Status Inquiry Results



Claim Search Results

Click on the Internal Control Number (ICN) link to view the Claim Details.

ICN	Member Name	Status	Payments	Charges	FDOS
9999999999999	Johnson, William	Paid	$22.09	$35.00	01/16/2002
9999999999999	Johnson, William	Paid	$22.09	$25.78	01/22/2003
9999999999999	Johnson, William	Paid	$22.09	$35.00	06/22/2004
9999999999999	Johnson, William	Paid	$22.09	$123.45	08/30/2003
9999999999999	Johnson, William	Paid	$22.09	$345.00	01/23/2005

1 2 3

Close

Appendix D: View Claim Status Panel

View Claim Status Panel

7.0 Sample MassHealth Transaction

276 Transaction Example

ISA*00* *00* *ZZ*110000000A *ZZ*DMA7384 *071004*1150*U*00401*264793000*0*T*>~
GS*HR*110000000A*DMA7384*20031210*1150*300000000*X*004010X093A1~
ST*276*0001~
BHT*0010*13**20070116~
HL*1**20*1~
NM1*PR*2*MASSHEALTH*****PI* 046002284~
PER*IC*CUSTOMER SERVICE*TE*8008412900~
HL*2*1*21*1~
NM1*41*1*JONES*LAURA*K***XX*1111111110~
HL*3*2*19*1~
NM1*1P*1*JONES*LAURA*K***XX*1111111110~
HL*4*3*22*0~
DMG*D8*19250307*M~
NM1*QC*1*SMITH*JOHN****MI*100000000999~
TRN*1*3640PHNOACC7~
REF*1K*2007199600155~
AMT*T3*21.85~
DTP*232*RD8*20070101-20070108~
SE*17*0001~
GE*1*300000000~
IEA*1*264793000~

277 Transaction Example

ISA*00* *00* *ZZ*DMA7384 *ZZ*110000000A *080114*1340*U*00401*000000482*0*T*:~
GS*HN*DMA7384*110000000A *20080114*134016*23*X*004010X093A1~
ST*277*0001~
BHT*0010*08*110000721A200801141340*20080114**DG~
HL*1**20*1~
NM1*PR*2*MASSHEALTH*****PI* 046002284~
PER*IC*CUSTOMER SERVICE*TE*8008412900~
HL*2*1*21*1~
NM1*41*1*JONES*LAURA*K***XX*1111111110~
HL*3*2*19*1~
NM1*1P*1*JONES*LAURA*K***XX*1111111110~
HL*4*3*22*0~
DMG*D8*19250307*M~NM1*QC*1*SMITH*JOHN****MI*100000000999~
TRN*2*3640PHNOACC7~
STC*A0:3*20080114**21.85*21.85*20071016*CHK~
REF*1K*2007199600155~
DTP*232*RD8*20070101-20070108~
SE*17*0001~
GE*1*23~
IEA*1*000000482~

8.0 Version Table

Version	Date	Section/Pages	Description
6.2	12/02	Entire document	Draft version issued
7.0	03/08	Entire document	Significant revisions throughout guide to reflect NewMMIS requirements
8.0	06/08	Entire document	Additional revisions throughout guide to reflect NewMMIS requirements, based on feedback from Version 7.0

9.0 Links to Online HIPAA Resources

The following is a list of online resources that may be helpful:

Accredited Standards Committee (ASC X12)

- ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. www.x12.org

American Hospital Association Central Office on ICD-9-CM (AHA)

- This site is a resource for the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes, used in medical transcription and billing, and for Level I HCPCS. www.ahacentraloffice.org

American Medical Association (AMA)

- This site is a resource for the Current Procedural Terminology, 4th Edition, codes (CPT-4). The AMA copyrights the CPT codes. www.ama-assn.org

Association for Electronic Health-care Transactions (AFEHCT)

- A health-care association dedicated to promoting the interchange of electronic health-care information. www.afehct.org

Centers for Medicare and Medicaid Services (CMS)

- CMS, formerly known as HCFA, is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Health-care Transactions and Code Sets Model Compliance Plan at www.cms.gov/hipaa/hipaa2/
- This site is the resource for information related to the Health-care Common Procedure Coding System (HCPCS). www.cms.gov/medicare/hcpcs
- This site is the resource for Medicaid HIPAA information related to the Administrative Simplification provision. www.cms.gov/medicaid/hipaa/adminsim

Designated Standard Maintenance Organizations (DSMO)

- This site is a resource for information about the standard setting organizations, and transaction change request system. www.hipaa-dsmo.org

Health Level Seven (HL7)

- HL7 is one of several ANSI accredited Standards Development Organizations (SDO), and is responsible for clinical and administrative data standards. www.hl7.org

MassHealth Provider Services

- This site assists providers with HIPAA, MassHealth billing and policy questions, as well as provider enrollment. www.mahealthweb.com

Medicaid HIPAA Compliant Concept Model (MHCCM)

- This site presents the Medicaid HIPAA Compliance Concept Model, information, and a toolkit. www.mhccm.org

National Council of Prescription Drug Programs (NCPDP)

- The NCPDP is the standards and codes development organization for pharmacy. www.ncpdp.org

National Uniform Billing Committee (NUBC)

- NUBC is affiliated with the American Hospital Association, and develops standards for institutional claims. www.nubc.org

National Uniform Claim Committee (NUCC)

- NUCC is affiliated with the American Medical Association. It develops and maintains a standardized data set for use by the non-institutional health-care organizations to transmit claims and encounter information. NUCC maintains the national provider taxonomy. www.nucc.org

Office for Civil Rights (OCR)

- OCR is the office within Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa

United States Department of Health and Human Services (DHHS)

- This site is a resource for the Notice of Proposed Rule Making, rules and other information about HIPAA. www.aspe.hhs.gov/admnsimp

Washington Publishing Company (WPC)

- WPC is a resource for HIPAA-required transaction implementation guides and code sets. www.wpc-edi.com/HIPAA

Workgroup for Electronic Data Interchange (WEDI)

- A workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA. www.wedi.org